the accounts could be left to his or her heirs. In addition, these private accounts ensure that the Federal Government can't come back at a later time and reduce benefits. Another key feature of these accounts is that low income workers, most for the first time, will have an opportunity to own assets and create wealth.

Another way the bill makes Social Security more progressive is by increasing the guaranteed benefits for those with low incomes. Other important provisions in the legislation will improve the Social Security benefits of widows, repeal the earnings test, and correct perverse work incentives inherent in the current system.

Finally, our proposal doesn't affect current retirees. They would continue under the current system. But by reducing the tremendous unfunded liability the system faces and restoring solvency to Social Security, current retirees are protected from the potential tax increases and benefit cuts that would be necessary to preserve the system. Seniors' benefits are far more secure under this plan than they are under current law.

Again, I am pleased to join Senators GREGG, KERREY, BREAUX, GRASSLEY, THOMPSON and ROBB in introducing this important legislation. And I encourage the rest of our colleagues to examine this bill carefully because I think it has the elements necessary to achieve a bipartisan agreement to save Social Security. The sooner we act, the better. Time is not on our side.

Mr. GRASSLEY. Mr. President, I rise today to join my colleagues in introducing the Bipartisan Social Security Reform Act of 1999.

We have crafted a responsible plan to save Social Security for generations to come. By making incremental, steady changes to the Social Security system, we will be able to ensure the long-term solvency of the program without taking Draconian measures.

Not only have we designed a responsible plan, but a bipartisan plan as well. No change to the Social Security system can be made without support from both sides of the aisle. Our bill represents a true bipartisan effort to save Social Security. The Bipartisan Social Security Reform Act is co-sponsored by four Republicans and three Democrats. Similar legislation has been introduced in the House of Representatives by Congressmen KOLBE and STENHOLM. This bipartisan, bicameral support is an excellent foundation on which to build, ensuring that the basis of the American retirement system remains financially sound for future generations.

The bipartisan plan would maintain a basic floor of protection through a traditional Social Security benefit, but two percentage points of the 12.4 percent payroll tax would be redirected to individual accounts. Individuals could invest their personal accounts in any combination of the funds offered through the Social Security system. An individual who invested his or her personal account in a bond fund would receive a guaranteed interest rate. However, individuals who wish to pursue a higher rate of return through investment in a fund including equities could do so.

Our proposal would eliminate the need for future payroll tax increases by advance funding a portion of future benefits through personal accounts. With individual accounts, we provide Americans with the tools necessary to build financial independence in retirement—especially to those who previously had limited opportunities to create wealth. Under our plan, they will be able to save for retirement and benefit from economic growth.

In putting together this legislation, this group has been conscious of how changes to Social Security would affect different populations. One group that I have been particularly concerned about is women. Let me explain how our bill addresses women's needs:

Women are more likely to move in and out of the workforce to care for children or elderly parents. They should not be punished for the time that they dedicate to dependents. Our proposal provides five ''drop-out'' years to the spouse with lower earnings in every two-earner couple.

Women, on average, earn less than men. The Bipartisan Social Security Reform Act would ensure that workers with wages below the national average would receive an additional $100 contribution annually to their personal accounts when they make a contribution of at least $1. Any subsequent contributions would receive a dollar-for-dollar match so that all workers would be guaranteed a minimum contribution of one percent of the taxable wage base. For this year, that contribution would be $726. Furthermore, all wage-earners would be permitted to save up to an additional $2,000 annually through voluntary contributions to personal accounts.

In addition, our proposal creates an additional bend point to the benefit formula to boost the replacement rate for low-income workers, many of whom are women.

Women live longer than men. At age 65, men are expected to live 15 more years, whereas women are expected to live almost 20 more. Our proposal addresses that reality by allowing money accumulated in individual accounts to be passed on to surviving spouses and children. Furthermore, our proposal would increase the widow's benefit to 75 percent of the combined benefits that a husband and wife would be entitled to based on their own earnings.

Congressional Republicans and Democrats and the administration all have established saving Social Security as a top priority. Now we must move ahead with the process and provide leadership. Each year that we wait to enact legislation to save Social Security, the changes must be more pronounced to make up for the lost time. I urge my colleagues to cosponsor the Bipartisan Social Security Reform Act.

The PRESIDING OFFICER. The Senator from Florida is under a previous order to speak for up to 10 minutes.

Mr. DOMENICI. Parliamentary inquiry. Is there any order subsequent to that?

The PRESIDING OFFICER. Yes. The Senator from New Mexico will be recognized, following the Senator from Florida, for up to 10 minutes.

Mr. DOMENICI. I thank the Chair.

The PRESIDING OFFICER. The Senator from Florida is recognized for 10 minutes.

Mr. DORGAN. Mr. President, I ask unanimous consent to follow the Senator from New Mexico.

The PRESIDING OFFICER. Without objection, it is so ordered. The Senator from Florida.

PATIENTS' BILL OF RIGHTS

Mr. GRAHAM. Mr. President, I come to the floor to voice my strong objection to hidden provisions which were inserted in the so-called last amendment during the consideration of the HMO Patients' Bill of Rights.

Last night, at approximately 8 o'clock, an amendment was offered which had over 250 pages. It had been represented throughout the debate that this amendment would be of a corrective, technical nature. There were several statements made on the floor that alterations, which had been agreed to verbally, would be incorporated in that final amendment. What we find is that quite a different thing has occurred.

First, I have found that several of the areas in which I had clear representations that refinements would be made were not made. In the area, for instance, of the emergency room, one of the key issues we spent considerable time debating had to do with poststabilization coverage. It was my understanding we had arrived at an agreement as to how to correct the language which all parties had appeared to agree would be an undue restriction on the rights of patients to receive proper care in an emergency room. I am sad to have to report that those changes were not incorporated in the final version of the legislation.

I am even more offended by the fact that while the changes we thought would be there were, at least in this instance, not obtained, but more so there were extraneous issues inserted, issues that had never been considered on the floor, never considered by a committee, never debated and unknown until they were unearthed, in the case of the issue I was to raise on page 252 and 253 of the so-called manager's amendment.

What is the provision I am so concerned about? It is section 901, ''Medicare Competitive Pricing Demonstration Project.'' If you want to get the full flavor of this, let me just quote:

(a) FINDING.—The Senate finds that implementing competitive pricing in the medicare program . . . of the Social Security Act is an important goal.

I could not agree more with that statement. So that would cause your heart to beat, your level of anticipation to be excited as you want to go on to what is the next paragraph that will implement that goal.

What is the next paragraph? It says: Notwithstanding what has been said above, the Secretary of Health and Human Services may not implement the Medicare demonstration project on competitive bidding; and, furthermore, notwithstanding any other provision, the Secretary of Health and Human Services may not implement any other competitive pricing project before January 1, 2001.

An absolute outrage.

Let me give you a little history of this.

When the Medicare program began to move beyond fee for service and to accept modern ways of health care, it did so in a rather cumbersome way. It said that we will reimburse a health maintenance organization on a formula; and the formula is 95 percent of the fee for service payments to Medicare beneficiaries within that community.

That may have some superficial rationale, but let me tell you what really happens.

First, if you happen to be in a community that has, for instance, a large teaching hospital or other complex medical center that serves a larger region, you are going to have high fee-for-service payments because of the nature of the health care that is delivered in that community. I would imagine that Rochester, MN, is a community that has relatively high fee for service because it has that great Mayo Clinic. I can tell you that Miami, FL, has high fee-for-service charges because it has a number of tertiary care hospitals. So because of that aberration that has nothing to do with what an HMO should be reimbursed, HMOs in those communities get 95 percent of fee for service.

There were some modifications made of that in the 1997 Balanced Budget Act, but the basic principle of a formula-based reimbursement which relates back to fee for service is still largely in place.

There is a second sequence of that in that we have very erratic fee levels for HMOs. The community that is immediately adjacent to the high fee-for-service community can have very low fee-for-service medicine delivered there, and therefore the HMOs get a much lower fee.

In my State, the differential from the highest to the lowest community is probably on the order of at least 100 percent from the highest to the lowest community that has an HMO program.

What is the consequence of that? The consequence of that is reported in today's Washington Post on page A–2. I ask unanimous consent to have that article printed in the RECORD immediately following my remarks.

The PRESIDING OFFICER. Without objection, it is so ordered.

(See Exhibit 1.)

Mr. GRAHAM. It states: ''HMOs Will Drop 327,000 Medicare Beneficiaries Next Year.''

We have just spent 4 days of debate on trying to avoid having people dropped from their HMOs, and we now have an announcement that just in the Medicare program alone—the Medicare program has 39 million participants, and approximately 4 million of those are in HMOs—out of that relatively small number of HMO beneficiaries, 327,000 are being dropped.

What does it say? It says that of those who are being dropped, 79,000 will be unable to enroll in another HMO because there are no other HMOs in their area.

When the industry was asked, why is this happening, their answer was: The managed care industry says HMOs are pulling out of Medicare because the Government isn't paying them enough.

You would think the industry would therefore want to have an alternative system that would provide adequate reimbursement, but not excessive reimbursement, and that the place to achieve that is the marketplace.

We heard a lot of talk this week about how we ought to have deference to the marketplace. I think what the HMOs want is to have free enterprise when it relates to service to the patients, and they want to have socialism when it relates to how much revenue they get paid.

So in 1997, in the face of all of these factors, the Congress, by a very strong vote—I think it was 76 votes in the Senate—passed the Balanced Budget Act which contained a provision that would actually start HMOs toward a competitive bidding process—the same process, incidentally, used by many other large HMO users, State and local governments, and in the private sector.

It was started very modestly, with a demonstration plan so that we could learn about what was involved in competitive bidding for HMOs. I, frankly, thought that was excessive caution, that we could have taken advantage of the experience that was already available by many other large users, but the thought was, let's go slow, let's do a demonstration project.

So since 1997, HCFA, the Federal agency with responsibility for managing Medicare, has been organizing this demonstration project. They selected Kansas City and Phoenix as the two sites for the demonstration project. They are about to start, and all of a sudden, on the 252nd page of what is supposed to be a corrective manager's amendment, we not only bar the demonstration projects that are about to commence but bar any other demonstration projects that may be suggested. Yet we started with a finding that we support competitive bidding.

Boy, I tell you, if this is the way they support the principle, you do not want them to be your parents and say they are going to give you good care.

Mr. DORGAN. Will the Senator yield for a short question?

Mr. GRAHAM. Mr. President, I ask unanimous consent for an additional 5 minutes.

The PRESIDING OFFICER. The Senator has 28 seconds remaining.

Mr. GRAHAM. I ask unanimous consent for an additional 5 minutes.

The PRESIDING OFFICER. If there is no objection.

Without objection, it is so ordered.

Mr. DORGAN. I want to inquire. I was unaware that that provision was in the package that was presented. Was the Senator from Florida aware, did he know of anyone else who was aware of that except perhaps the folks who wrote it?

Mr. GRAHAM. We have not found anybody who was aware of it except some diligent soul who actually got to page 252 of the bill sometime late last night or this morning and discovered this. I might say, it is very difficult to even get copies of this amendment.

We have known for several years that the HMO industry did not want competitive bidding. They like the socialized formula system that exists today. They are attempting in any way they can, including this stealth attack late last night on page 252, to kill competitive bidding.

Unfortunately, just as with the issue of the HMO bill we have been debating, on the issue of patients versus the bottom line of the HMOs, the HMOs won in the Patients' Bill of Rights, and they have won again by killing competitive bidding. I say they have won. I think it is a Pyrrhic victory.

I think the Senator from North Dakota might recall an event that, as Yogi Berra said, it is deja vu all over again. I think it was just about 3 years ago, in a similar stealth maneuver, that we discovered there was embedded in a large bill a provision that would have given the tobacco industry a $50 billion tax break. Once that issue surfaced, it could not stand the light of day. It slowly withered, died, and has not been resurrected.

I suggest the light of day will be shed on what the HMO industry has done by inserting this amendment on page 252 of a technical amendment, the fact they are using this as a means of avoiding the rigors of the marketplace, they are using this to avoid a rationalization of the compensation that HMOs receive from their patients so that we don't continue this pattern of 32,700 people being dropped. I can tell my colleagues, most of these people are people who come from rural areas. They come from small towns where they don't have high fee-for-service medicine. The HMOs want to skim off those areas that have high fee-for-service, where they can get a formula that results in a very rushed reimbursement level. They don't want to provide services, and they don't even want to have a competitive bidding process that can arrive at what the marketplace says they should be paying for those HMO

beneficiaries in smaller communities of America.

What we are seeing, again, is the bottom line winning out over the rights, the interests, and the health of patients. We are watching as Medicare patients are dumped on the street. Is that the HMO industry's idea of reform? It is my idea of a travesty, and it is one that we need to bring to the attention of America. And we, as the Senate, need to expunge this dark page, page 252, and its companion, page 253, from our records. I hope we will, at the first opportunity, do so.

I thank the Chair.

EXHIBIT 1

[From the Washington Post, July 16, 1999]

HMOs WILL DROP 327,000 MEDICARE BENEFICIARIES NEXT YEAR

(By David S. Hilzenrath)

About 327,000 of the 6.2 million Medicare beneficiaries nationwide who belong to HMOs will be abandoned by their health plans next year, the government said yesterday.

Of those, 79,000 will be unable to enroll in another health maintenance organization as 41 health plans withdraw from the federal health insurance program for the elderly and disabled and another 58 stop serving Medicare beneficiaries in particular areas, according to the agency that runs Medicare.

Medicare beneficiaries who lose their HMO coverage have two or three alternatives: They can choose another HMO, if one is available; they can revert to standard fee-for-service Medicare coverage; and they can buy ''Medigap'' policies to supplement the standard benefits.

But there is no guarantee that they can find a Medigap policy with prescription drug coverage, which is one of the main reasons some Medicare beneficiaries choose HMOs.

In Maryland and Virginia, 33,000 beneficiaries—26.9 percent of those with HMO coveage—will lose their current coverage, and 27,000 will be unable to replace it with another HMO.

An HMO industry group recently predicted that more than 250,000 beneficiaries would be affected by the changes, but the Department of Health and Human Services released the final tally based on notices HMOs were required to submit by July 1.

This year, a larger number of beneficiaries—407,000—were abandoned by their HMOs, but a smaller number—51,000—were left without an HMO option.

The managed-care industry says HMOs are pulling out of Medicare because the government isn't paying them enough, but the government says the HMOs' actions reflect broader industry trends.

MANAGED HEALTH CARE REFORM—HMO LIABILITY

Mr. BINGAMAN. Mr. President, over the past few days, my Democratic colleagues and I presented a number of arguments which clearly laid out the need for managed health care reform.

The ability to hold insurance companies accountable for their decisions is a critical element in ensuring the overall quality of patient protections.

While we will continue to present our case in a variety of ways, I would like to take this opportunity to relate a story that was shared with me just a few weeks ago about a young girl from Albuquerque, New Mexico.

Anna, 6 years old at the time, was a very active and energetic young girl and excited about entering first grade that year. One evening, Anna went with her parents and her brothers and sisters to a softball game. She and other children went off to play in an area near the softball field. Suddenly, some of the children came running towards the adults, screaming for help. Anna had caught her foot in a gate. Her foot was bleeding profusely and she was in agonizing pain. She was immediately rushed to the local emergency room.

After Anna was examined by her doctor and after a conversation with her family's HMO, it was determined that Anna would not be admitted to the hospital that night.

Anna's family reluctantly took her home that night where she was in pain throughout the evening. Her family was forced to watch their small, frail daughter lay in bed in agony.

The next morning, her mother was worried because Anna's foot was purple, swollen, and cold. Anna was in tremendous pain and had a fever. Her parents did not hesitate any longer and Anna was rushed back to the emergency room.

This time she was admitted immediately and treated on an emergency basis, but it was too late and her family's worst fears were realized. Anna had a raging infection that had already destroyed half of her foot which had to be amputated.

Anna had two surgeries and spent 6 weeks in the hospital. She will live with this deformity forever.

Unbelievably, her family's HMO has delayed paying for the 6 weeks she was in the hospital to have her foot amputated and grated at a cost of $23,000.00.

Anna's family paid for the protection of health insurance. What they received in return was a possible delay of critical medical service which has left Anna disfigured and has ruined her family's credit.

To the amazement of anyone who hears this story, under current law, Anna's HMO will not be held accountable for their decisions.

Under the Democratic plan, Anna and her family would have legal recourse like any other American has in this country when they are wronged by a business.

The Democratic plan simply states that if a patient is injured or killed as a result of an insurance company's decision, the insurance company can be held liable under state law.

Let me be clear. This will not open the flood gates to more litigation and raise the cost of health insurance.

It doe not override states' rights. It simply says that whatever rights a given state chooses to grant shall not be blocked by federal legislation.

Without adoption of the Democratic plan, stories like Anna's will continue to be told. I understand Anna is quite a young girl and she will go on. But she and her family will struggle with this nightmare.

The Democratic plan is not about lawyers—it is about people like Anna and protecting their rights.

Anna, her family and millions like them in this country are waiting for us to do just that.

THE ILLEGAL PURCHASE OF FIREARMS

Mr. LEVIN. Mr. President, we've all heard the saying, ''if at first you don't succeed, try, try, again.'' It's a lesson we've been taught since childhood. It's a lesson used to teach children to be persistent and work hard if they want to achieve their goals. It is also a lesson that applies to the purchase of firearms, and it is one that Benjamin Smith knew all too well.

Over the Fourth of July weekend, the majority of Americans were celebrating the birth of our nation. But the long holiday weekend produced yet another tragedy, made possible by the free flow of deadly firearms. A single man, Benjamin Smith, with a hatred for life, allegedly used a .22 caliber handgun and a .380 caliber semi-automatic handgun to murder two people and wound nine before ending his own life.

The alleged gunman had a history of violence, a protection order filed against him, and belonged to an organization that espouses hatred toward minorities, yet, he was still able to purchase deadly firearms, all because he was persistent. Approximately one week before his killing spree, he had applied to purchase firearms from a licensed firearms dealer in Illinois. He obtained an owner identification card, filled out an application, and expected to retrieve his weapons shortly thereafter. A few days later, however, he returned to buy the weapons and was rejected by the licensed dealer after failing to pass the Illinois state background check. Unfortunately, Benjamin Smith knew his lesson, ''if at first you don't succeed, try, try again.''

Benjamin Smith knew of other means to obtain firearms. He knew that although he was not permitted to purchase a gun from a licensed dealer, he would have few problems buying a gun on the street, from an unlicensed dealer. He knew that federal law requires that background checks be conducted by licensed dealers, but he also knew of a large secondary market in the United States that permits the free flow of weapons in to the hands of those who can not pass background checks. And, because he knew how easy it is to obtain a gun in the United States, Benjamin Smith was able to try, again, to purchase firearms for his killing spree.

Smith's second attempt to purchase guns was successful and as a result, this dangerous young man was equipped with the two handguns believed to be used in the several Independence Day shootings. Because of this secondary market that allows easy accessibility of firearms, the nation is